



Child Find Referral Form
Please complete form and return to:

Durango School District 9-R Child Find
201 E. 12th Street
Durango, CO 81301
Phone: 970.247.5411 ext. 1107 Fax: 970.375.3826
Email: childfind@durangoschools.org

Child's Information:

Child's Name (First, Middle, Last): _____
Date of Birth: ___/___/___ Child's Race: _____ Gender: ___Male___Female
Parent/Guardian: _____ Relation to the child: _____
Address: _____
Phone: _____ Email: _____
Child's primary language: _____ Language spoken in the home: _____
Interpreter Needed: ___Yes___No If Yes, Language: _____
Child Attends: ___Headstart___Private School: _____ 9-R School: _____
School Schedule: _____ Nap Time: _____
Referring Provider/Person: _____
Phone #: _____ Fax #: _____ Email: _____

Areas of concern:
___Communication___Fine/Gross Motor___Social/Emotional___Cognitive___Adaptive
Please explain: _____

If this referral is from a provider:
Date of ASQ or other developmental screening: ___/___/___ Date of Hearing Screen:
___/___/___ Pass:___Fail:___ Date of Vision Screen: ___/___/___ Pass:___Fail:___
(Please include copy of the **entire developmental screening tool**, such as the ASQ as well as results of any hearing and vision screening. This will avoid duplication of efforts and allow for a more timely and appropriate evaluation.)

Referral and Consent to Share Information:

I am requesting that my child be referred to Durango School District 9-R Child Find for a developmental screening. I understand this process may lead to an evaluation for special education eligibility.
Parent/Guardian: _____ Date: ___/___/___

I give my consent for exchange of information between Durango School District 9-R Child Find and (referral source) _____ regarding this referral
Parent/Guardian: _____ Date: ___/___/___